

		FOR OFF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER

I. IDPH Facility ID Number: <u>0038893</u>					II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER				
Facility Name: <u>Center Home for Hispanic Elderly</u>					<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/00</u> to <u>06/30/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>				
Address: <u>1401 N. California</u> <u>Chicago</u> <u>60622</u> <div>NumberCityZip Code</div>									
County: <u>Cook</u>									
Telephone Number: <u>773-782-8700</u> Fax # <u>773-276-0465</u>									
IDPA ID Number: <u>36-3527934001</u>									
Date of Initial License for Current Owners: <u>02/18/82</u>					<div> <div>Officer or Administrator of Provider</div> <div>(Signed) _____ (Date) _____</div> <div>(Type or Print Name) <u>Gilberto Torres</u></div> <div>(Title) <u>Administrator</u></div> </div>				
Type of Ownership:					<div> <div>Paid Preparer</div> <div>(Signed) _____ (Date) _____</div> <div>(Print Name and Title) <u>Daniel L. Malone</u></div> <div>(Firm Name & Address) <u>D.L.M. Financial Advisory Services</u></div> <div>(Telephone) <u>708-361-4295</u> Fax <u>708-448-3228</u></div> </div>				
<div> <div> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <div> <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust </div> </div> <div> <input type="checkbox"/> PROPRIETARY <div> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other </div> </div> <div> <input type="checkbox"/> GOVERNMENTAL <div> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other </div> </div> </div>					<div> <div>MAIL TO: OFFICE OF HEALTH FINANCE</div> <div>ILLINOIS DEPARTMENT OF PUBLIC AID</div> <div>201 S. Grand Avenue East</div> <div>Springfield, IL 62763-0001</div> <div>Phone # (217) 782-1630</div> </div>				
IRS Exemption Code <u>501(c3)</u>									
In the event there are further questions about this report, please contact: Name <u>DAN MALONE</u> Telephone Number: <u>708-3614295</u>									

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Facility Name & ID Number Center Home for Hispanic Elderly# 0038893 Report Period Beginning: 07/01/00 Ending: 06/30/2001**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,170</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>56,940</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,140</u>			<u>13,140</u>	8
9	SNF/PED					9
10	ICF	<u>39,839</u>			<u>39,839</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>52,979</u>			<u>52,979</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 93.04%)

D. How many bed-hold days during this year were paid by Public Aid?
2,623 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

MEALS FOR ADULT DAY CARE

F. Does the facility maintain a daily midnight census? No

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 02/18/82

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary Not Applicable

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: JUNE 30,2001 Fiscal Year: JUNE 30,2001

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

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Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/00 Ending: 06/30/2001
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	330,353	42,365	10,287	383,005		383,005	(53,612)	329,393		1
2	Food Purchase		292,429		292,429		292,429	14	292,443		2
3	Housekeeping	77,090	43,902	982	121,974	(10,487)	111,487	8,131	119,618		3
4	Laundry	77,071	30,629		107,700		107,700		107,700		4
5	Heat and Other Utilities			135,813	135,813		135,813	35,718	171,531		5
6	Maintenance	126,110	11,159	49,977	187,246		187,246	22,755	210,001		6
7	Other (specify):*							0			7
8	TOTAL General Services	610,624	420,484	197,059	1,228,167	(10,487)	1,217,680	13,006	1,230,686		8
	B. Health Care and Programs										
9	Medical Director			2,328	2,328		2,328	0	2,328		9
10	Nursing and Medical Records	1,821,703	101,966	194,986	2,118,655	10,487	2,129,142	0	2,129,142		10
10a	Therapy	37,328			37,328		37,328	0	37,328		10a
11	Activities	108,292	3,909	8,845	121,046		121,046	0	121,046		11
12	Social Services	112,098		1,000	113,098		113,098	0	113,098		12
13	Nurse Aide Training	17,382			17,382		17,382	0	17,382		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	2,096,803	105,875	207,159	2,409,837	10,487	2,420,324		2,420,324		16
	C. General Administration										
17	Administrative	223,545		511,547	735,092		735,092	(549,926)	185,166		17
18	Directors Fees							0			18
19	Professional Services			87,830	87,830		87,830	11,073	98,903		19
20	Dues, Fees, Subscriptions & Promotions			10,372	10,372		10,372	279	10,651		20
21	Clerical & General Office Expense	171,241	16,185	76,236	263,662		263,662	348,341	612,003		21
22	Employee Benefits & Payroll Taxes			612,843	612,843		612,843	44,800	657,643		22
23	Inservice Training & Education			3,305	3,305		3,305	0	3,305		23
24	Travel and Seminar			21,930	21,930		21,930	243	22,173		24
25	Other Admin. Staff Transportation			1,396	1,396		1,396	149	1,545		25
26	Insurance-Prop.Liab.Malpractice			40,307	40,307		40,307	6,645	46,952		26
27	Other (specify):*			11,755	11,755		11,755	(11,755)			27
28	TOTAL General Administration	394,786	16,185	1,377,521	1,788,492		1,788,492	(150,150)	1,638,342		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,102,213	542,544	1,781,739	5,426,496		5,426,496	(137,143)	5,289,353		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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(1)

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

THE SINGLE RECLASSIFICATION IS TO PROPERLY CLASSIFY
DISPOSABLE AND CLOTH DIAPERS TO NURSING SUPPLIES

SUPPLEMENTAL SCHEDULE												
RECONCILIATION OF EXPENSES PER COST REPORT WITH AUDIT REPORT												
DESCRIPTION	PER C/R	PER TRIAL		PER COST REPORT		PER TRIAL BALANCE		PER TRIAL BALANCE		EQUIPMENT	TRAINING	DIFFERENCE
		BALANCE	DIFFER.	INTEREST	TAX	ASSISTANCE	FOOD	TRANSPORTATION	TELEPHONE			TOTAL
SALARIES	#####	2843528	258,685									258685
FRINGE BENEFITS	612,843	409,437	143,406									143406
DIETARY	675,434	715138	(39,704)								287	-19123
FOOD	292,429	250381	42,048				-12803	15502	4608	4792		54851
NURSING/												
ACIVITIES	#####	2317869	91,968				-6326	700	16127	2149	1055	102198
HOUSEKEEPING												
AND MAINTENANCE	552,733	627606	(74,873)	-38079			-52		2304	-6941		-43683
G & A	#####	1092471	83,178	-1405	-86112	99575	-6425	-16202	-23039		-1342	60001
ANCILLARY COSTS	84,942	0	84,942		86112							
OTHER EXPENSE	0	99575	(99,575)			-99575						0
DEPRECIATION, INTERE	196,661	117794	78,867	39484	0	0						39383
TOTAL	9102741	8533799	568,942	0	0	0						55,701

COMPARISON OF PAYROLL COSTS BY FUNCTIONAL AREA

DESCRIPTION	PER TRIAL BALANCE AND COST REPORT		
	PAGE 3	PAGE 20	DIFFERENCE
DIETARY	330353	278537	51816
HOUSEKEEPING	77090	77090	0
LAUNDRY	77071	77071	0
MAINTENANCE	126110	126110	0
NURSING	1821703	1839178	-17475
NURSE AID TRAINING	17382		17382
THERAPY	37328	37238	90
ACTIVITIES	108292	108292	0
SOCIAL SERVICES	112098	112097	1
ADMINISTRATION	223545	237719	-14174
CLERICAL	171241	171240	1
TOTAL	3102213	3064572	37641

RECONCILIATION OF THE DIFFERENCES BETWEEN THE TRIAL BALANCE/COST REPORT AND PAGE 20 STAFFING:

DESCRIPTION	BEGINNING		ENDING		DIFFERENCE
	VACATION ACCRUAL	VACATION ACCRUAL	BEGINNING ACCRUAL	ENDING ACCRUAL	
DIETARY				15365	
HOUSEKEEPING				5376	
LAUNDRY				4080	
MAINTENANCE				6168	
NURSING				92274	
NURSE AID TRAINING					
THERAPY				9086	
ACTIVITIES				5568	
SOCIAL SERVICES				2910	
ADMINISTRATION				8295	
CLERICAL				7020	
TOTAL	-40173	42657	-152285	156142	6341

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/00 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
	D. Ownership	1	2	3	4	5	6	7	8	9	10
30	Depreciation			128,240	128,240		128,240	135,369	263,609		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			45,123	45,123		45,123	65,337	110,460		32
33	Real Estate Taxes							0			33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			23,298	23,298		23,298	1,976	25,274		35
36	Other (specify):*							0			36
37	TOTAL Ownership			196,661	196,661		196,661	202,682	399,343		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers							0			39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			84,942	84,942		84,942	0	84,942		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			84,942	84,942		84,942		84,942		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,102,213	542,544	2,063,342	5,708,099	0	5,708,099	65,538	5,773,637		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

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Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning: 07/01/00

Ending: 6/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in ti general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	176,692	L17C3	34
35	Other- Attach Schedule	(111,154)	VARIOUS	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 65,538		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 65,538		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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CENTER HOME FOR HISPANIC ELDERLY
ALLOCATION OF COSTS ASSOCIATED WITH SUPPORT SERVICES
PROVIDED BY PADRES CORPORATION
FOR THE FISCAL YEAR END JUNE 30,2001

TOTAL EXPENSES REPORTED BY: CENTER HOME FOR HISPANIC ELDERLY	TOTAL OPERATING EXPENSES	PERCENTAGE OF TOTAL OPERATING EXPENSES
	5708099	33.80%
CASA CENTRAL SOCIAL SERVICES	11178178	66.20%
TOTAL COMBINED EXPENSES	16886277	100.00%

OPERATING EXPENSES OF PADRES CORPORATION FOR FISCAL YEAR END JUNE 30,2001									
DESCRIPTION	AMOUNT	ADJUSTMENTS TO OPERATING EXPENSE	ADJUSTED TOTAL OPERATING EXPENSE	ALLOCATION PERCENTAGE	AMOUNT ALLOCATED TO CENTER HOME	MEDICAID COST REPORT REFERENCE PAGE, LINE, COL.	TOTAL ADJUSTMENT EACH LINE NUMBER OF THE COST REPORT		
STAFF SALARIES	1179435	-206557	972878	33.80%	328863.724	PG. 3, LINE 21, COL.7	355749.2226		
FICA EXPENSE	87803	-15377.12911	72425.87089	33.80%	24482.24918	PG. 3, LINE 22, COL.7			
UNEMPLOYMENT COMP.	6777	-1186.870653	5590.129347	33.80%	1889.641615	PG. 3, LINE 22, COL.7			
WORKER'S COMPENSATION	10077	-1764.806784	8312.193216	33.80%	2809.785827	PG. 3, LINE 22, COL.7			
HEALTH INSURANCE	50720	-8882.703193	41837.29681	33.80%	14142.33771	PG. 3, LINE 22, COL.7			
DENTAL INSURANCE	11	-1.926453768	9.073546232	33.80%	3.067147375	PG. 3, LINE 22, COL.7			
LIFE INSURANCE	1738	-304.3796954	1433.620305	33.80%	484.6092852	PG. 3, LINE 22, COL.7			
TSR	1650	-288.9680652	1361.031935	33.80%	460.0721062	PG. 3, LINE 22, COL.7			
DISABILITY INSURANCE	1269	-222.242712	1046.757288	33.80%	353.8372744	PG. 3, LINE 22, COL.7	44799.86988		
PROFESSIONAL SERVICES									
OTHER PROFESSIONAL SERVIC	18700	-18700							
AUDIT AND ACCOUNTING	30267	-5300.725109	24966.27489	33.80%	8439.395418	PG. 3, LINE 19, COL.7			
DATA PROCESSING	9445	-1654.123258	7790.876742	33.80%	2633.564269	PG. 3, LINE 19, COL.7			
TOTAL PROFESSIONAL SERVICES	58412			33.80%	0	PG. 3, LINE 19, COL.7	11072.95969		
OFFICE SUPPLIES	9793	-1715.06925	8077.93075	33.80%	2730.597658	PG. 3, LINE 21, COL.7			
HOUSE KEEPING SUPPLIES	29162	-5107.204071	24054.79593	33.80%	8131.286522	PG. 3, LINE 3, COL.7	8131.286522		
KITCHEN SUPPLIES	-1165	1165	0	33.80%	0	PG. 3, LINE 1, COL.7			
FOOD EXPENSE	49	-8.581475876	40.41852412	33.80%	13.6627474	PG. 3, LINE 2, COL.7	13.6627474		
COMPUTER SUPPLIES	3518	-616.1149415	2901.885059	33.80%	980.9294968	PG. 3, LINE 21, COL.7			
BUILDING REPAIRS AND MAINTENANCE	34535	-6048.189171	28486.81083	33.80%	9629.448599	PG. 3, LINE 6, COL.7			
BUILDING INSPECTION FEES	752	-131.6993849	620.3006151	33.80%	209.6813478	PG. 3, LINE 6, COL.7	22755.44521		
PROPERTY AND LIABILITY INSURANCE	20301	-3555.357995	16745.642	33.80%	5660.559896	PG. 3, LINE 26, COL.7	6645.393035		
PHYSICAL EXAMS	38	-6.655022108	31.34497789	33.80%	10.59560002	PG. 3, LINE 22, COL.7			
SCAVENGER SERVICE	12284	-2151.323463	10132.67654	33.80%	3425.167123	PG. 3, LINE 6, COL.7			
EXTERMINATING	4555	-797.7269922	3757.273008	33.80%	1270.077845	PG. 3, LINE 6, COL.7			
ELEVATOR MAINTENANCE	2619	-458.671129	2160.328871	33.80%	730.2599068	PG. 3, LINE 6, COL.7			
ELECTRICITY	88310	-15465.92111	72844.07889	33.80%	24623.61679	PG. 3, LINE 5, COL.7			
GAS	38683	-6774.637374	31908.36263	33.80%	10786.04199	PG. 3, LINE 5, COL.7	35717.76768		
STAFF LITERATURE	153	-26.79522059	126.2047794	33.80%	42.66123167	PG. 3, LINE 21, COL.7			
LICENSE	40	-7.00528643	32.99471357	33.80%	11.15326318	PG. 3, LINE 20, COL.7	279.3892427		
WATER	1105	-193.5210376	911.4789624	33.80%	308.1088954	PG. 3, LINE 5, COL.7			
MORTGAGE INTEREST	234324	-41037.66843	193286.3316	33.80%	65336.93104	PG. 4, LINE 32, COL.7	65336.93104		
TELEPHONE	42101	-7373.239099	34727.7609	33.80%	11739.08833	PG. 3, LINE 21, COL.7			
POSTAGE	5056	-885.4682047	4170.531795	33.80%	1409.772466	PG. 3, LINE 21, COL.7			
EQUIPMENT REPAIRS AND MAINTENANCE	26495	-4640.126599	21854.8734	33.80%	7387.6427	PG. 3, LINE 6, COL.7			
SOFTWARE MAINTENANCE	5787	-1013.489814	4773.510186	33.80%	1613.598351	PG. 3, LINE 21, COL.7			
EQUIPMENT RENTAL	1916	-335.55322	1580.44678	33.80%	534.2413064	PG. 5, LINE 35, COL.7			
AUTO LEASE	5172	-905.7835353	4266.216465	33.80%	1442.116929	PG. 5, LINE 35, COL.7	1976.358236		
AUTO INSURANCE	2106	-368.8283305	1737.171669	33.80%	587.2193065	PG. 3, LINE 26, COL.7			
AUTO REPAIR AND MAINTENANCE	370	-64.79889947	305.2011005	33.80%	103.1676844	PG. 3, LINE 6, COL.7			
AUTO REGISTRATION AND LICENSE	278	-48.68674069	229.3132593	33.80%	77.51517911	PG. 3, LINE 20, COL.7			
DIRECTOR AND OFFICER LIABILITY INSI	1426	-249.7384612	1176.261539	33.80%	397.6138324	PG. 3, LINE 26, COL.7			
OTHER EXPENSE	977	-171.104121	805.895879	33.80%	272.4184532	PG. 3, LINE 21, COL.7			
CONFERENCES AND CONVENTIC	873	-152.8903763	720.1096237	33.80%	243.4199689	PG. 3, LINE 24, COL.7	243.4199689		
STAFF TRANSPORTATION	535	-93.69570599	441.304294	33.80%	149.1748951	PG. 3, LINE 25, COL.7	149.1748951		
MEMBERSHIP DUES	295	-51.66398742	243.3360126	33.80%	82.25531596	PG. 3, LINE 20, COL.7			
PUBLICATIONS	389	-68.12641053	320.8735895	33.80%	108.4654844	PG. 3, LINE 20, COL.7			
AWARDS RECOGNITION	587	-102.8025784	484.1974216	33.80%	163.6741372	PG. 3, LINE 22, COL.7			
ADVERTISING	5802	-5802	0	33.80%	0	PG. 3, LINE 21, COL.7			
OUTSIDE PRINTING	5312	-930.3020378	4381.697962	33.80%	1481.153351	PG. 3, LINE 21, COL.7			
BANK CHARGES	2283	-399.826723	1883.173277	33.80%	636.5724961	PG. 3, LINE 21, COL.7			
MISCELLANEOUS EXPENSE	2618	-458.4959968	2159.504003	33.80%	729.9810752	PG. 3, LINE 21, COL.7			
PENALTIES	31	-31	0	33.80%	0	PG. 3, LINE 21, COL.7			
CONTRIBUTIONS	140000	-140000	0	33.80%	0	PG. 3, LINE 21, COL.7			
DEPRECIATION: EQUIPMENT	12598	-2206.314961	10391.68504	33.80%	3512.720239	PG. 4, LINE 30, COL.7			
FURNITURE AND FIXTURES	301978	-52886.05964	249091.9404	33.80%	84201.00273	PG. 4, LINE 30, COL.7			
BUILDING IMPROVEMENT: EQUIPMENT	63947	-11199.17628	52747.82372	33.80%	17830.44302	PG. 4, LINE 30, COL.7			
SOFTWARE	106962	-18732.48618	88229.51382	33.80%	29824.38341	PG. 4, LINE 30, COL.7	135368.5494		
AMORTIZATION LAND IMPROVEM	16044	-2809.820387	13234.17961	33.80%	4473.573862	PG. 3, LINE 21, COL.7			
TOTALS	2780	-486.8674069	2293.132593	33.80%	775.1517911	PG. 3, LINE 21, COL.7			
	2631666	-595646.3621	2036019.638		688239.4301		688239.4301		

ADJUSTMENT TO FRINGE BENEFITS:		% OF TOTAL	TOTAL FRINGE BENEFIT	TOTAL ADJUSTMENT
TOTAL SALARIES UNRELATED TO CENTER HOME	206557	17.51%	160045	28029.02667
TOTAL OF ALL SALARIES	1179435			

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary columns are linked to pages Summary A and B.

STATE OF ILLINOIS Page 5A

Facility Name Center Home for Elderly Elderly

DOB 000000000

Report Period Beginning: 07/01/00

Ending: 06/30/00

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. See the columns highlighted are B thru G.
2. Push the Print Other Adjustments

Print Other

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending: 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A	Operating Expenses												SUMMARY	
	A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	0	176,692	0	0	0	0	0	0	0	0	0	176,692	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	176,692	0	0	0	0	0	0	0	0	0	176,692	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	176,692	0	0	0	0	0	0	0	0	0	176,692	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home for Hispanic Elderly **#** 0038893 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

**Print Summary
B**

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY	
													TOTALS	
	D. Ownership												(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	176,692	0	0	0	0	0	0	0	0	0	176,692	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning 07/01/00 Ending: 06/30/2001

Show Pgs 6A thru

Show Pgs 6E thru

Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CASA CENTRAL	CHICAGO	NOT FOR PROFIT
				PADRES CORP.	CHICAGO	NOT FOR PROFIT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form. REFER TO ATTACHED SCHEDULE FOR THE DETAILS OF THE COST A

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 OTHER ADMINISTRATIVE	\$ 511,547	CASA CENTRAL AND PADRES CORPORATION	NONE	\$ 688,239	\$ 176,692	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 511,547			\$ 688,239	\$ * 176,692	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Sum_6
176692.43

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/00 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8			
						Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			Schedule V. Line & Column Reference	
							Hours	Percent	Description				Amount
1	NOT APPLICABLE								\$ N/A		1		
2											2		
3											3		
4											4		
5											5		
6											6		
7											7		
8											8		
9											9		
10											10		
11											11		
12											12		
13								TOTAL	\$		13		

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST RE

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

, the name(s)
 PORTS.

Facility Name & ID Number Center Home for Hispanic Elderly# 0038893 Report Period Beginning: 07/01/00 Ending: 5/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PADRES CORPORATION

Street Address _____

City / State / Zip Code

CHICAGO, IL, 60622

Phone Number

(773) 645-2300

Fax Number

()

B. Show the allocation of costs below. If necessary, please attach worksheets.

PLS REFER TO THE ATTACHED SCHEDULE

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Print Preview

Facility Name & ID Number Center Home for Hispanic Elderly# 0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	AMERICAN NATIONAL BANK	X		BUILDING MORTGAGE	\$5,085.00		\$ 500,000	\$ 356,308	07/06/05	9.500%	\$ 28,558	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	AMERICAN NATIONAL BANK	X		WORKING CAPITAL	VARIES		875,000	875,000	VARIOUS	VARIABLE	16,565	6							
7	WASHINGTON SQUARE		X	WORKING CAPITAL	VARIES		130,272	130,272	VARIOUS	VARIABLE		7							
8									WORKING CAPITAL INTEREST IS COMBINE			8							
9	TOTAL Facility Related				\$5,085.00		\$ 1,505,272	\$ 1,361,580				\$ 45,123	9						
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$				\$	14						
15	TOTALS (line 9+line14)						\$ 1,505,272	\$ 1,361,580				\$ 45,123	15						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **Center Home for Hispanic Elderly**# **0038893** Report Period Beginning: **07/01/00** Ending: **06/30/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	Not Applicab	2
3. Under or (over) accrual (line 2 minus line 1).	\$	"" ""	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	"" ""	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	"" ""	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	"" ""	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	"" ""	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996	Not Applicable	8
	1997	"" "" ""	9
	1998	"" "" ""	10
	1999	"" "" ""	11
	2000	"" "" ""	12

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

 A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

 C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

 D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Not Applicable

 F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>55,145</u>	<u>1981</u>	<u>\$ 45,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>55,145</u>		<u>\$ 45,000</u>	<u>3</u>

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Facility Name & ID Number Center Home for Hispanic Elderly
XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	149		1981		\$ 255,000	\$ 10,200	25	\$ 10,200	\$	\$ 198,900
5										
6										
7										
8										
	Improvement Type**									
9	Improvements		1982		2,251	90	25	90		1,755
10	Improvements: FIRE SPRINKLER; WINDOWS & OTHER IT		1983		205,573	8,223	25	8,223		152,123
11	Improvements: HEATING; FIRE ALARM & OTHER ITEMS		1984		72,587	2,904	25	2,904		50,811
12	:: FIRE ALARMS; WHEELCHAIR RAMP & OTHER ITEMS		1985		41,435	1,657	25	1,657		28,147
13	: ELEVATOR; NURSES STATION & REAR STAIRWAY		1986		236,110	9,444	25	9,444		146,388
14	DOOR; CARPETING & AIR CONDITIONING LINES		1988		1,153	46	25	46		623
15	NEW ROOF, TUCKPOINTING		1990		38,398	2,560	15	2,560		28,159
16	ELEVATOR REPAIR AND TUCKPOINTING		1992		10,325	688	15	688		6,252
17	ELEVATOR REPAIR		1993		67,891	4,527	15	4,527		37,317
18	Improvements		1994		44,641	2,976	15	2,976		22,640
19	Elevator Repairs and Roof Repairs		1995		42,324	2,822	15	2,822		19,076
20	Front Door		1995		11,843	789	15	789		5,323
21	Electrical Improvements		1995		213,730	14,289	15	14,289		99,740
22	Boiler Repairs		1995		15,681	1,045	15	1,045		6,736
23	Water Heater		1995		2,025	135	15	135		934
24	Plumbing Repairs		1995		1,550	103	15	103		689
25	Laundry and Kitchen Repairs		1996		10,500	700	15	700		4,086
26	4th Floor Construction		1996		10,300	687	15	687		3,924
27	Boiler Repairs		1996		2,180	145	15	145		848
28	Electric Upgrade		1996		895	60	15	60		318
29	Kitchen Repairs		1997		4,200	280	15	280		1,291
30	Elevator Repairs		1997		23,440	1,563	15	1,563		7,067
31	Electrical Repairs		1997		6,985	466	15	466		2,137
32	Install New Doors		1997		1,675	112	15	112		475
33	Boiler Repairs		1997		3,573	238	15	238		1,012
34	TOTALS FROM PAGES 12a ,12b&12C					#	#	#	#	#
35	REWIRE KITCHEN AND SUMP PUMPS		1991		41,225	2,748		2,748		27,485
36					\$	\$		\$	\$	

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	BATHROOM REMODELING	1998	\$ 96,661	\$		\$	\$	\$ 22,455	37
38	ELEVATOR REPAIR	1998	3,000					683	38
39	LAUNDRY PUMPS	1998	4,422					995	39
40	ELECTRICAL WORK	1998	31,052					6,600	40
41	AIRCONDITIONER	1998	933					202	41
42	KITCHEN WORK	1998	3,903					802	42
43	BOILER REPAIRS	1998	1,875					385	43
44	DAMPERS	1998	6,220					1,279	44
45	DOORS AND FRAMES	1998	20,263					4,217	45
46	BUILDING IMPROVEMENTS: ELECTRICAL TRANSFRER SW	1999	9,591					1,812	46
47	KITCHEN FIRE EXTINGUISHING SYSTEM	1999	1,500					283	47
48	TOASTER WIRING	1999	1,370					244	48
49	BOILER REPAIRS	1999	2,977					496	49
50	BASE BOARD RADIATORS	1999	1,000					167	50
51	BASE BOARD RADIATORS	1999	800					133	51
52	ELECTRICAL TRANSFER SWITCHES	1999	3,500					544	52
53	ACCESS PANELS	1999	3,125					486	53
54	ACCESS PANELS	1999	1,025					148	54
55	FIRE DAMPERS	1999	1,550					223	55
56	ROOF REPAIRS	1999	1,000					144	56
57	ROOF REPAIRS	1999	1,000					144	57
58	WATER HEATER	1999	3,490					465	58
59	ELECTRICAL REPAIRS	1999	2,443					326	59
60	EXIT SIGNS	1999	1,089					133	60
61	WATER HEATERS	1999	1,490					149	61
62	METAL FENCING	1999	1,000					133	62
63	METAL FENCING	1999	800					106	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,574,569	\$ #REF!		\$ #REF!	\$ #REF!	\$ 898,010	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,574,569	\$ #REF!		\$ #REF!	\$ #REF!	\$ 898,010	1
2	REPLACE HANDRAILS		1,999					2,311	2
3	UPGRADE TELEPHONE SYSTEM		1,999					335	3
4	BOILER AND GAS LINE REPLACEMENT AND REPAIR		1,999					532	4
5	EMERGENCY SYSTEM UPGRADE		1,999					458	5
6	DAIRY COMPRESSOR AND STAIRWAY LIGHTS		2,000					845	6
7	COMPUTER WIRING		2,000					706	7
8	WATER HEATER		2,000					659	8
9	FLOOR TILE		2,000					86	9
10	KITCHEN REHAB		2,000					984	10
11	HANDRAILS		2,000					1,125	11
12	ROOF REPAIRS		2,000					2,300	12
13	EMERGENCY GENERATOR		2,000					4,998	13
14	ROOF REPAIRS		2,000					2,023	14
15	SUMP PUMPS		2,001					264	15
16	ALARM SYSTEM		2,001					139	16
17	GENERATOR TANK REMOVAL		2,001					111	17
18	SEWAGE PUMP		2,001					247	18
19	ALARM SYSTEM		2,001					199	19
20	HANDRAILS		2,001					539	20
21	WINDOWS		2,001					158	21
22	WATER TANK		2,001					182	22
23	TANK REMOVAL		2,001					207	23
24	WINDOWS		2,001					38	24
25	TUCKPOINTING		2,001					10	25
26	HANDRAIL/ ARCHITECTURAL FEES		2,001					29	26
27	ELECTRICAL WIRING		2,001					6	27
28	AIRCONDITIONING LINES		1,989					1,348	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,628,567	\$ #REF!		\$ #REF!	\$ #REF!	\$ 918,849	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,628,567	\$ #REF!		\$ #REF!	\$ #REF!	\$ 918,849	1
2	DISPOSAL VALVE	2001	400					2	2
3	EMERGENCY GENERATOR INSTALL WIRING	2001	550					3	3
4	BOILER	2001	4,429					25	4
5	FLOOR TILE	2001	512					3	5
6	SELECTOR UNIT FOR BUILDING ELEVATOR	2001	5,200					29	6
7	CONSTRUCTION IN PROGRESS		8,500						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,648,158	\$ #REF!		\$ #REF!	\$ #REF!	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 1,648,158	\$		\$	\$	\$ 918,911	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,648,158	\$		\$	\$	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 1,648,158	\$		\$	\$	\$ 918,911	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,648,158	\$		\$	\$	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 1,648,158	\$		\$	\$	\$ 918,911	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,648,158	\$		\$	\$	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,648,158	\$		\$	\$	\$ 918,911	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,648,158	\$		\$	\$	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 1,648,158	\$		\$	\$	\$ 918,911	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,648,158	\$		\$	\$	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 1,648,158	\$		\$	\$	\$ 918,911	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,648,158	\$		\$	\$	\$ 918,911	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly# 0038893

Report Period Beginning:

07/01/00

Ending:

06/30/2001**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 281,405	\$ 29,402	\$ 29,402	\$	3/10 YRS	\$ 191,689	37
38	Current Year Purchases	1,196	242	242		3/10 YRS	242	38
39	Fully Depreciated Assets	72,097					72,097	39
40								40
41	TOTALS	\$ 354,698	\$ 29,644	\$ 29,644	\$		\$ 264,028	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,648,158	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 918,911	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS NOT APPLICABLE

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2.

CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3.

CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS

(d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record facility received training

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities	
DROP-OUTS	
1. From this facility	
2. From other facilities	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

1

the amount of income you
; aides from other facilities.

(f)

(f)

XIV. SPECIAL SERVICES (Direct Cost) (See instruction NOT APPLICABLE

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 65,897	\$	1
2	Cash-Patient Deposits			2
	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,576,976		3
4	Supply Inventory (priced at)	23,149		4
5	Short-Term Investments			5
6	Prepaid Insurance	126,627		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	671,371		8
9	Other(specify):	544		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,464,564	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	45,000		13
14	Buildings, at Historical Cost	255,000		14
15	Leasehold Improvements, at Historical Cos	1,599,625		15
16	Equipment, at Historical Cost	354,698		16
17	Accumulated Depreciation (book methods)	(1,182,939)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,071,384	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,535,948	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 146,562	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(150)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,258		30
	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	OTHER CURRENT LIABILITIES			33
34	INTER COMPANY A/P PADRES CORP.	696,031		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	BANK LINES OF CREDIT	1,005,272		36
37	REFUNDS	20,686		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,078,659	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	337,731		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 337,731	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,416,390	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,119,558	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,535,948	\$	48

*(See instructions.)

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		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,382,534	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,382,534	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(262,976)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (262,976)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,119,558	24 *

* This must agree with page 17, line 47.

Print Preview

Facility Name & ID Number Center Home for Hispanic Elderly

0038893

Report Period Beginning: 07/01/00

Ending:

06/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,390,154	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,390,154	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	49,621	24
25	Interest and Other Investment Income***	4,483	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54,104	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER INCOME	865	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 865	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,445,123	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 1,228,167	31
32	Health Care	2,409,837	32
33	General Administration	1,788,492	33
B. Capital Expense			
34	Ownership	196,661	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	84,942	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,708,099	40
41	Income before Income Taxes (line 30 minus line 40)**	(262,976)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (262,976)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet

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